UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

BRENDA MORLOCK,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	**Case No. 4:04 CV 556 HEA (LMB)**
	)	
JO ANNE B. BARNHART,	)	
Commissioner of Social Security,	)	
	)	
Defendant.	)	

REPORT AND RECOMMENDATION
OF UNITED STATES MAGISTRATE JUDGE

This is an action under 42 U.S.C. § 405(g) for judicial review of defendant's final decision denying Brenda Morlock's application for Disabled Widow's Insurance Benefits under Title II of the Social Security Act. The cause was referred to the undersigned United States Magistrate Judge for a Report and Recommendation pursuant to 28 U.S.C. § 636 (b). Plaintiff has filed a Brief in Support of Complaint (Document Number 10). Defendant has filed a Brief in Support of the Answer. (Doc. No. 12).

Procedural History

On February 19, 2002, plaintiff filed her application for Disabled Widow's Insurance Benefits, claiming that she became unable to work due to her disabling condition on February 26, 1995. (Tr. 75-77). This claim was denied initially, and following an administrative hearing, plaintiff's claim was denied in a written opinion by an Administrative Law Judge (ALJ), dated October 24, 2003. (Tr. 62-65, 12-19). Plaintiff then filed a request for review of the ALJ's

decision with the Appeals Council of the Social Security Administration (SSA), which was denied. (Tr. 8-11, 5-7). Thus, the decision of the ALJ stands as the final decision of the Commissioner. See 20 C.F.R. §§ 404.981, 416.1481 (2003).

Evidence Before the ALJ

A. ALJ Hearing

Plaintiff's administrative hearing was held on June 26, 2003. (Tr. 20). Plaintiff was present and was represented by counsel. (Tr. 22). The ALJ began by admitting a number of exhibits into evidence. (Id.). Plaintiff's attorney then examined plaintiff, who testified that she was 59, and lived in a house alone. (Tr. 23). Plaintiff stated that she had a son who lived in a state psychiatric institution, who was not dependent upon her for support. (Id.). Plaintiff testified that she is not working and that she earns income through her deceased husband's benefits and from interest drawn from savings accounts. (Tr. 24). Plaintiff stated that her husband died in November 1993. (Id.). Plaintiff testified that she received a high school diploma and that she did not attend college or receive any vocational training. (Id.). Plaintiff stated that the last time she worked was approximately 20 to 25 years ago. (Id.).

Plaintiff testified that she is able to drive as long as she is careful. (Tr. 25). Plaintiff stated that she drives about 12 to 13 minutes away to church two to three times a week, to the store about once a week, and to visit her son 30 miles away once a week. (Id.). Plaintiff testified that she is unable to work because she cannot concentrate enough to follow instructions, she has pressure in her head, and she suffers from headaches. (Tr. 26). Plaintiff stated that she is able to sit in a chair for two to three hours as long as the chair is comfortable. (Id.). Plaintiff testified that she is able to stand for about an hour on a good day but on bad days she can only stand for a

few minutes. (Tr. 26-27). Plaintiff stated that she can walk for a block or more if she is feeling good and that she can lift a gallon of milk. (Tr. 27).

Plaintiff testified that she experiences constant back pain. (Id.). Plaintiff stated that performing mild stretching exercises provides relief. (Id.). Plaintiff testified that she underwent physical therapy for her back about a year ago for a few months and that she plans to begin physical therapy again. (Tr. 28). Plaintiff stated that she experiences pain or pressure in her head constantly, which prevents her from thinking or functioning and causes a lack of energy. (Id.). Plaintiff explained that she experiences some relief when she places pressure on her head or when she eats certain foods. (Id.). Plaintiff testified that she has been experiencing these symptoms with her back, head, and her decreased energy level since 1996. (Id.). Plaintiff stated that her back pain was not as severe initially, although her head pain was severe from the beginning. (Tr. 29). Plaintiff testified that medication helped her symptoms for the first few months but its effectiveness gradually decreased. (Id.). Plaintiff stated that Dr. Pierre J. Moeser told her that her symptoms could be caused by fibromyalgia,[1] neurologists believed she was experiencing muscle tension headaches, and other doctors believed her symptoms were caused by stress. (Tr. 30).

Plaintiff testified that she sleeps four to five hours a night, which is enough "to get by" yet she has no energy. (Tr. 30-31). Plaintiff stated that she makes sandwiches and salads for herself but her mother, who lives next door, has been cooking most of her meals for the last few years.

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[1]A syndrome of chronic pain of musculoskeletal origin but uncertain cause. The American College of Rheumatology has established diagnostic criteria that include pain on both sides of the body both above and below the waist, as well as in an axial distribution; additionally there must be point tenderness in at least 11 of 18 specified sites. Stedman's Medical Dictionary, 671 (27th Ed. 2000).

(Tr. 31). Plaintiff testified that when she shops for groceries she only buys a few things. (Id.). Plaintiff stated that, other than attending church and visiting her mother and son, she typically leaves her house about one other time a week to go to the store. (Tr. 32). Plaintiff testified that she does not see friends anymore, other than when she attends church. (Id.).

Plaintiff testified that she is currently seeing a counselor to help deal with her pain. (Id.). Plaintiff stated that she occasionally feels hopeless about the future although seeing Dr. Paul Lohkamp has helped. (Tr. 33). Plaintiff testified that her sleep has decreased due to her back pain and head pain. (Id.). Plaintiff further testified that she is less motivated than she used to be, she experiences feelings of guilt or disappointment about her life, and she experiences problems with her memory. (Id.). Plaintiff stated that she is unable to engage in activities that she used to enjoy. (Tr. 34). Plaintiff testified that she is not currently taking any medication except over-the-counter ibuprofen. (Id.).

The ALJ next examined plaintiff, who testified that she lives by herself. (Id.). Plaintiff stated that she performs all of the household chores herself, although she does not keep her home "real tidy." (Tr. 35). Plaintiff testified that she cared for her daughter's child five to six years ago when her daughter was ill. (Id.). Plaintiff explained that she played with the child on the floor, changed his diapers, and cooked his meals. (Id.). Plaintiff testified that she has two daughters but one passed away in 1994. (Id.). Plaintiff stated that the daughter that passed away had two small children, for whom she cared immediately following her daughter's death. (Tr. 35-36).

The ALJ then examined plaintiff's daughter, Jamie Hartman, who testified that she was 38 and was employed as a substitute teacher. (Tr. 36). Ms. Hartman stated that plaintiff cared for her son five years ago when she was pregnant with her second child. (Tr. 36-37). Ms. Hartman

explained that plaintiff helped prepare meals, took care of her son, and helped clean. (Tr. 37).

Plaintiff's attorney next examined Ms. Hartman, who testified that her mother suffers from problems with sleeping, memory, concentration, and the ability to retain information. (Tr. 37-38). Ms. Hartman attributed plaintiff's symptoms to fibromyalgia. (Tr. 38). Ms. Hartman testified that, after plaintiff was diagnosed with fibromyalgia, her condition worsened and she became more limited in her ability to do housework. (Id.). Ms. Hartman stated that plaintiff has had problems with her memory and concentration for five to ten years. (Id.). Ms. Hartman explained that her symptoms gradually worsened and they have been at the current level of severity for three to five years. (Tr. 39). Ms. Hartman stated that plaintiff's level of activity and movement has been at the current level for the past two to three years. (Id.).

Ms. Hartman testified that she sees her mother four to five times a week. (Tr. 40). Ms. Hartman stated that she goes to plaintiff's home and that plaintiff travels to her home. (Id.). Ms. Hartman testified that she also talks to her mother on the telephone approximately five times a week. (Id.). Ms. Hartman stated that she has been assisting her mother by accompanying her to doctor appointments, helping with her finances, helping with heavy lifting and cleaning, and checking in on her regularly for the last year or two. (Tr. 40-41). Ms. Hartman testified that she would have helped her mother sooner but her mother did not complain. (Tr. 41). Ms. Hartman stated that her children are aged four and six. (Tr. 42). Ms. Hartman testified that plaintiff engages in light activities with her children, such as sitting down on the couch and watching them play. (Id.). Ms. Hartman stated that plaintiff does not pick her children up because they are two heavy for her to lift. (Tr. 42-43).

Plaintiff's attorney stated that she was awaiting the receipt of medical records that she had

requested from Dr. Anderson, Dr. Lafferty, and Dr. Bonner. (Tr. 32). The ALJ thus indicated that he would hold the record open for 30 days. (Id.).

B. Relevant Medical Records

The record reveals that plaintiff was treated by chiropractor Laura A. Priehe from June 4, 1999 to September 10, 1999. (Tr. 258). Dr. Priehe stated in a state agency questionnaire that plaintiff suffered from "mild neck pain and severe headache." (Id.). On June 4, 1999, plaintiff underwent x-rays of her spinal column, which were negative aside from postural changes and degenerative joint disease.[2] (Tr. 268).

Plaintiff saw Ahmed Jafri, M.D. on May 27, 1999 and February 21, 2000. (Tr. 251-255). Dr. Jafri indicated that plaintiff tried Amitriptyline,[3] which did not help, and that plaintiff continued to experience headaches. (Tr. 251). Dr. Jafri prescribed Prozac[4] on February 21, 2000. (Tr. 252).

Plaintiff presented to Christian Hospital on October 3, 2000, complaining of abdominal pain. (Tr. 239-47). Plaintiff was discharged on the same day, with instructions to keep a scheduled appointment with her primary care provider, Scott Anderson, M.D. (Tr. 246). Plaintiff underwent a gynecological exam, barium enema, and abdominal ultrasound, all of which were normal. (Tr. 226-28).

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[2]Disease characterized by deterioration of the lumbar vertebrae. See Stedman's at 467.

[3]Amitriptyline is an antidepressant indicated for the relief of depression. See Physician's Desk Reference (PDR), 2213 (59th Ed. 2005).

[4]Prozac is indicated for the treatment of major depressive disorder. See PDR at 1874.

On May 15, 2001, plaintiff saw William Logan, M.D., for evaluation of her "rather peculiar head pains." (Tr. 236). Dr. Logan noted "I am not even sure I would categorize this as a headache, but more of an odd feeling that Ms. Morlock gets across her forehead." (Id.). Dr. Logan indicated that plaintiff had seen an Ear Nose & Throat doctor, a neurologist, an allergist, and had two MRI[5] scans of the brain, and no abnormalities were found. (Id.). Dr. Logan noted that plaintiff was not taking any prescription medications. (Id.). Upon examination, Dr. Logan found "nothing visibly wrong on her forehead or nose. She has no real tenderness." (Id.). Dr. Logan also reported that plaintiff's neurological examination was normal. (Tr. 237). Dr. Logan commented that plaintiff had "many unusual explanations and odd associations with chewing soft and hard food that I just cannot reconcile in a disease process." (Id.). Dr. Logan suggested that plaintiff's symptoms were "simply an outlet for the stress she is having in her life, particularly as it relates to her son." (Id.). Dr. Logan's impression was that plaintiff's symptoms were "simply a manifestation of an underlying anxiety disorder." (Id.). Dr. Logan started plaintiff on Klonopin.[6] (Id.).

Plaintiff underwent physical therapy from August 2001 to December 2001. (Tr. 181-95). Plaintiff was discharged after 12 visits on December 14, 2001. (Tr. 181). At this time, Debbie Lavender, PT, noted that plaintiff reported a "significant decrease" in her back pain. (Id.).

On May 3, 2002, W. Bruce Donnelly, M.D., a state agency physician, expressed the opinion that there was insufficient evidence prior to October 2000 to evaluate function. (Tr. 103).

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[5]Magnetic Resonance Imaging. Stedman's at1135.

[6]Klonopin is indicated for the treatment of panic disorder. See PDR at 2895.

Plaintiff saw Dr. Jafri again on June 28, 2002. (Tr. 175). Dr. Jafri's impression was tension type headaches and anxiety. (Tr. 177). Dr. Jafri recommended medication for the headaches and a psychiatric consultation for the anxiety. (Id.).

Dr. Logan referred plaintiff to Jo J. Bonner, M..D., for treatment of her forehead pain. (Tr. 144-46). On November 13, 2002, Dr. Bonner recounted plaintiff's treatment history, noting that prior tests had shown no abnormalities, and that plaintiff had not seen a psychiatrist despite recommendations by Dr. Logan and Dr. Jafri. (Tr. 144). Dr. Bonner reported that plaintiff was not taking any prescription medications at that time. (Tr. 145). Upon physical examination, Dr. Bonner found no abnormalities and stated that the etiology of plaintiff's forehead pain was "not totally clear." (Tr. 145-46). Dr. Bonner noted that plaintiff experienced difficulty concentrating, even for directions to follow during the exam. (Tr. 145). Dr. Bonner expressed the opinion that plaintiff suffers from "significant anxiety, perhaps depression." (Tr. 146). Dr. Bonner recommended psychiatric treatment for plaintiff's anxiety and depression. (Id.).

Plaintiff saw Paul Lohkamp, LCSW, for a psychiatric evaluation on December 9, 2002. (Tr. 153-54). Mr. Lohkamp found that plaintiff was depressed, with "severe somatization/pain syndrome.[7]" (Tr. 154). Specifically, Mr. Lohkamp stated that plaintiff was "fixated on managing, monitoring, controlling pain." (Id.). Mr. Lohkamp recommended psychotherapy and medical management from Dr. Lafferty. (Id.). Mr. Lohkamp saw plaintiff on nine subsequent occasions, from December 2002 to June 2003. (Tr. 156-64). Plaintiff often complained of forehead pain, stress, and depression. (Id.).

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[7]The process by which psychological needs are expressed in physical symptoms, such as pain. See Stedman's at 1655.

Plaintiff saw Julie Lafferty, M.D., on December 10, 2002. (Tr. 151-52). Dr. Lafferty diagnosed plaintiff with Major Depressive Disorder,[8] recurrent, moderate with anxiety; and Generalized Anxiety Disorder.[9] (Tr. 152). Dr. Lafferty prescribed Lexapro.[10] (Id.).

Plaintiff saw Pierre J. Moeser, MD on February 20, 2003, for a consultation for "body pains and headaches." (Tr. 168-69). Dr. Moeser's impression was "fibromyalgia syndrome with some underlying anxiety and depression." (Tr. 168). Dr. Moeser also found that plaintiff may have some spondylosis[11] and some degenerative joint disease. (Id.). Dr. Moeser started plaintiff on Amitriptyline again but noted that plaintiff cannot tolerate medications well. (Tr. 168-69). Dr. Moeser also recommended exercise and possible physical therapy. (Tr. 169). Plaintiff saw Dr. Moeser again on April 21, 2003, at which time she continued to complain of headaches, severe fatigue, and non-restful sleep. (Tr. 166). Dr. Moeser's diagnosis was "some degenerative joint disease," spondylosis, and "severe fibromyalgia with underlying anxiety and depression." (Id.). Dr. Moeser again recommended increased exercise and a trial of medication. (Id.).

The ALJ's Determination

The ALJ made the following findings:

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[8]A mental disorder characterized by sustained depression of mood; sleep and appetite disturbances; and feelings of worthlessness, guilt, and hopelessness. See Stedman's at 478.

[9]A psychological disorder in which anxiety or morbid fear and dread accompanied by autonomic changes are prominent features. See Stedman's at 526.

[10]Lexapro is indicated for the treatment of major depressive disorder. See Stedman's at 1282.

[11]Stiffening of the vertebra. See Stedman's at 1678.

1. The claimant was born on July 26, 1943.

2. The claimant is the widow of Albert W. Morlock, a wage earner who died fully insured on November 17, 1993. The claimant has not remarried.

3. The period during which the claimant must establish that she was under a disability (the "prescribed period") extends from November 1, 1993, through October 31, 2000.

4. The claimant has not engaged in substantial gainful activity since 1964.

5. The record as a whole, including all medical evidence, establishes that the claimant, through the end of the prescribed period, had no severe impairment.

6. The claimant's subjective complaints and other allegations are not fully credible, for the reasons set forth in the body of this decision.

7. The claimant was not under a disability as defined by the Social Security Act at any time through October 31, 2000, the end of the prescribed period.

(Tr. 18-19).

The ALJ's final decision reads as follows:

> It is the decision of the Administrative Law Judge that, based on the application filed on January 28, 2002, the claimant is not entitled to disabled widow's insurance benefits under sections 202(e) and 223, respectively, of the Social Security Act.

(Tr. 19).

Discussion

A. Standard of Review

Judicial review of a decision to deny Social Security benefits is limited and deferential to the agency. See Ostronski v. Chater, 94 F.3d 413, 416 (8th Cir. 1996). The decision of the SSA will be affirmed if substantial evidence in the record as a whole supports it. See Mapes v. Chater, 82 F.3d 259, 262 (8th Cir. 1996). Substantial evidence is less than a preponderance, but enough that a reasonable mind might accept it as adequate to support a conclusion. See Kelley v.

Callahan, 133 F.3d 583, 587 (8th Cir. 1998). It is not the court's task "to review the evidence and make an independent decision." See Mapes, 82 F.3d at 262. If, after review, it is possible to draw two inconsistent positions from the evidence and one of those positions represents the Commissioner's findings, the denial of benefits must be upheld. See id. The reviewing court, however, must consider both evidence that supports and evidence that detracts from the Commissioner's decision. See Johnson v. Chater, 87 F.3d 1015, 1017 (8th Cir. 1996)(citing Woolf v. Shalala, 3 F.3d 1210, 1213 (8th Cir. 1993)). "[T]he court must also take into consideration the weight of the evidence in the record and apply a balancing test to evidence which is contrary." Burress v. Apfel, 141 F.3d 875, 878 (8th Cir. 1998). The analysis required has been described as a "searching inquiry." Id.

B. The Determination of Disability

To establish entitlement to Disabled Widow's Insurance Benefits, the following criteria must be met: (1) the claimant must have attained the age of 50; (2) the claimant must be the widow of the wage earner; (3) the claimant must be unmarried; and (4) the claimant must be under a disability as defined in the Act. See 42 U.S.C. § 402(e)(1).

The Social Security Act defines disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months." 42 U.S.C. § 416 (I) (1) (a); 42 U.S.C. § 423 (d) (1) (a). The claimant has the burden of proving that s/he has a disabling impairment. See Ingram v. Chater, 107 F.3d 598, 601 (8th Cir. 1997).

The SSA Commissioner has established a five-step process for determining whether a

person is disabled. See 20 C.F.R. §§ 404.1520, 416.920; Bowen v. Yuckert, 482 U.S. 137, 141-42, 107 S. Ct. 2287, 2291, 96 L. Ed. 2d. 119 (1987); Fines v. Apfel, 149 F.3d 893, 894-895 (8th Cir. 1998). First, it is determined whether the claimant is currently engaged in "substantial gainful employment." If the claimant is, disability benefits must be denied. See 20 C.F.R. §§ 404.1520, 416.920 (b). Step two requires a determination of whether the claimant suffers from a medically severe impairment or combination of impairments. See 20 C.F.R §§ 404.1520 (c), 416.920 (c). To qualify as severe, the impairment must significantly limit the claimant's mental or physical ability to do "basic work activities." Id. Age, education and work experience of a claimant are not considered in making the "severity" determination. See id.

If the impairment is severe, the next issue is whether the impairment is equivalent to one of the listed impairments that the Commissioner accepts as sufficiently severe to preclude substantial gainful employment. See 20 C.F.R. §§ 404.1520 (d), 416.920 (d). This listing is found in Appendix One to 20 C.F.R. 404. 20 C.F.R. pt. 404, subpt. P, App. 1. If the impairment meets or equals one of the listed impairments, the claimant is conclusively presumed to be impaired. See 20 C.F.R. §§ 404.1520 (d), 416.920 (d). If it does not, however, the evaluation proceeds to the next step which inquires into whether the impairment prevents the claimant from performing his or her past work. See 20 C.F.R. § 404.1520 (e), 416.920 (e). If the claimant is able to perform the previous work, in consideration of the claimant's residual functional capacity (RFC) and the physical and mental demands of the past work, the claimant is not disabled. See id. If the claimant cannot perform his or her previous work, the final step involves a determination of whether the claimant is able to perform other work in the national economy taking into

consideration the claimant's residual functional capacity, age, education and work experience. See 20 C.F.R. §§ 404.1520 (f), 416.920 (f). The claimant is entitled to disability benefits only if s/he is not able to perform any other work. See id. Throughout this process, the burden remains upon the claimant until s/he adequately demonstrates an inability to perform previous work, at which time the burden shifts to the Commissioner to demonstrate the claimant's ability to perform other work. See Beckley v. Apfel, 152 F.3d 1056, 1059 (8th Cir. 1998).

The Commissioner has supplemented this five-step process for the evaluation of claimants with mental impairments. See 20 C.F.R. §§ 404.1520a (a), 416.920a (a). A special procedure must be followed at each level of administrative review. See id. Previously, a standard document entitled "Psychiatric Review Technique Form" (PRTF), which documented application of this special procedure, had to be completed at each level and a copy had to be attached to the ALJ's decision, although this is no longer required. See 20 C.F.R. §§ 404.1520a (d), (d) (2), (e), 416.920a (d), (d) (2), (e); 65 F.R. 50746, 50758 (2000). Application of the special procedures required is now documented in the decision of the ALJ or Appeals Council. See 20 C.F.R. §§ 404.1520a (e), 416.920a (e).

The evaluation process for mental impairments is set forth in 20 C.F.R. §§ 404.1520a, 416.920a. The first step requires the Commissioner to "record the pertinent signs, symptoms, findings, functional limitations, and effects of treatment" in the case record to assist in the determination of whether a mental impairment exists. See 20 C.F.R. §§ 404.1520a (b) (1), 416.920a (b) (1). If it is determined that a mental impairment exists, the Commissioner must indicate whether medical findings "especially relevant to the ability to work are present or absent." 20 C.F.R. §§ 404.1520a (b) (2), 416.920a (b) (2). The Commissioner must then rate the degree

of functional loss resulting from the impairments in four areas deemed essential to work: activities of daily living, social functioning, concentration, and persistence or pace. See 20 C.F.R. §§ 404.1520a (b) (3), 416.920a (b) (3). Functional loss is rated on a scale that ranges from no limitation to a level of severity which is incompatible with the ability to perform work-related activities. See id. Next, the Commissioner must determine the severity of the impairment based on those ratings. See 20 C.F.R. §§ 404.1520a (c), 416.920a (c). If the impairment is severe, the Commissioner must determine if it meets or equals a listed mental disorder. See 20 C.F.R. §§ 404.1520a(c)(2), 416.920a(c)(2). This is completed by comparing the presence of medical findings and the rating of functional loss against the paragraph A and B criteria of the Listing of the appropriate mental disorders. See id. If there is a severe impairment but the impairment does not meet or equal the listings, then the Commissioner must prepare a residual functional capacity assessment. See 20 C.F.R. §§ 404.1520a (c)(3), 416.920a (c)(3); Pratt, 956 F.2d at 834-35; Jones v. Callahan, 122 F.3d 1148, 1153 n.5 (8th Cir. 1997).

C. Plaintiff's Claims on Appeal

Plaintiff raises two claims on appeal of the Commissioner's decision, both of which relate to evidence from after the relevant period. In order to be entitled to Disabled Widow's Insurance Benefits, a claimant must show that her disability began no later than seven years after the wage earner died or seven years after the claimant was last entitled to survivor's benefits, whichever is later. See 20 C.F.R. §§ 404.335 (2004). In this case, plaintiff's husband died insured on November 17, 1993. As such, plaintiff must show an onset of disability prior to October 31, 2000.

Plaintiff first argues that the ALJ erred by failing to consider plaintiff's mental

impairments. Plaintiff also argues that the ALJ erred in failing to consider evidence from after the expiration of her insured status. The undersigned finds these arguments persuasive and finds that the ALJ's failure to consider evidence of plaintiff's mental impairments was error. Because plaintiff's two claims are interconnected, the undersigned will discuss them together.

Plaintiff claims that the ALJ erred by failing to consider the effects of her mental impairments on her ability to function. Specifically, plaintiff contends that the ALJ only considered objective medical evidence of physical abnormalities prior to 2002. Plaintiff also argues that the ALJ erred by not following SSR 83-20 and inferring from the record a disability onset date prior to October 31, 2000. Respondent argues that the ALJ properly determined that plaintiff did not have a severe impairment during the relevant period.

Step two of the sequential evaluation process requires a determination of whether the claimant suffers from a medically severe impairment or combination of impairments. See 20 C.F.R §§ 404.1520 (c), 416.920 (c). To qualify as severe, the impairment must significantly limit the claimant's mental or physical ability to do "basic work activities." Id. Basic work activities include physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling as well as capacities for seeing, hearing, and speaking. See 20 C.F.R. § 404.1520(b)(1),(2). Basic work activities also include understanding, carrying out, and remembering simple instructions, use of judgment, responding appropriately to supervision, co-workers and usual work situations, and dealing with changes in a routine work setting. See 20 C.F.R. § 404.1520(b)(3)-(6). Age, education and work experience of a claimant are not considered in making the "severity" determination. See 20 C.F.R §§ 404.1520 (c), 416.920 (c). While the burden is not great, the claimant bears the burden at step two to demonstrate a severe

impairment that significantly limits the ability to perform basic work activities. See Mittlestedt v. Apfel, 204 F.3d 847, 852 (8th Cir. 2000); Caviness v. Massanari, 250 F.3d 603, 605 (8th Cir. 2001). The sequential evaluation process may be terminated at step two when the claimant's impairment or combination thereof would have no more than a minimal effect on the claimant's ability to work. See Caviness, 264 F.3d at 605.

SSR 83-20 is a statement of the policy and process for determining the onset date of disability, and enumerates a number of factors to be considered, including: a claimant's allegations, work history, and medical evidence. See SSR 83-20 at 1-2. In pertinent part, SSR 83-20 provides:

> In determining the date of onset of disability, the date alleged by the individual should be used if it is consistent with all the evidence available. When the medical or work evidence is not consistent with the allegation, additional development may be needed to reconcile the discrepancy. However, the established onset date must be fixed based on the facts and can never be inconsistent with the medical evidence of record.
>
> Precise Evidence Not Available -- Need for Inferences
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> In some cases, it may be possible, based on the medical evidence to reasonably infer that the onset of a disabling impairment occurred some time prior to the date of the first recorded medical examination, e.g., the date the claimant stopped working. How long the disease may be determined to have existed at a disabling level of severity depends on an informed judgment of the facts in the particular case. This judgment, however, must have a legitimate medical basis. At the hearing, the administrative law judge (ALJ) should call on the services of a medical advisor when onset must be inferred. If there is information in the file indicating that additional medical evidence concerning onset is available, such evidence should be secured before inferences are made.
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> ...
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> The available medical evidence should be considered in view of the nature of the impairment (i.e., what medical presumptions can reasonably be made about the course of the condition). The onset date should be set on the date when it is most reasonable to conclude from the evidence that the impairment was sufficiently severe to prevent the individual from engaging in SGA (or gainful activity) for a continuous

> period of at least 12 months or result in death. Convincing rationale must be given for the date selected.

SSR 83-20 at 2-3. The date of diagnosis of the impairment is not necessarily equivalent to the onset date of disability. See Williams v. Secretary of Health & Human Services, 847 F.2d 301, 304 (6th Cir. 1988). See also Swanson v. Secretary of Health & Human Services, 763 F.2d 1061, 1065 (9th Cir. 1985) ("[T]he critical date is the date of *onset* of disability *not* the date of diagnosis").

In the instant case, plaintiff contends that the medical evidence in the record demonstrates the presence of the severe impairments of depression, anxiety, and fibromyalgia. The objective medical evidence is supportive of the presence of these impairments prior to October 31, 2000. Plaintiff was treated by a chiropractor from June 1999 to September 1999, during which time she complained of "mild neck pain and severe headache." (Tr. 258). Plaintiff complained of headaches to Dr. Jafri on May 27, 1999 and February 21, 2000. (Tr. 251-55). Dr. Jafri prescribed Prozac on February 21, 2000. (Tr. 252). Plaintiff presented to Christian Hospital on October 3, 2000, complaining of abdominal pain. (Tr. 239-47). It was noted that plaintiff had a history of "nerve endings in head," which had been present for two to three months. (Tr. 243). Plaintiff's discharge records indicate that the cause of her abdominal pain was not certain, although "the signs of a serious problem may take more time to appear." (Tr. 246). Plaintiff was instructed to keep a scheduled appointment with Dr. Anderson on October 5, 2000. (Id.).

On May 15, 2001, plaintiff saw neurologist Dr. Logan for evaluation of her headaches, which he characterized as an "odd feeling." (Tr. 236). Plaintiff reported that her headaches began three to four years prior to her visit and were initially "annoying," but developed into a

"continuous sensation that is with her day and night." (Id.). Plaintiff stated that when her head pain is particularly bad, she has trouble thinking and processing. (Id.). Plaintiff also complained of a very poor energy level and difficulty sleeping. (Id.). Plaintiff indicated to Dr. Logan that she saw an allergist who told her that she had "some little nerve endings that are not right." (Id.). Dr. Logan commented that plaintiff had "unusual explanations" and "odd associations" with food that he could not "reconcile in a disease process." (Tr. 237). Dr. Logan suggested that plaintiff's symptoms were a manifestation of an underlying anxiety disorder. (Id.).

On June 28, 2002, Dr. Jafri's impression was tension type headaches and anxiety. (Tr. 177). Dr. Jafri recommended medication for the headaches and a psychiatric consultation for the anxiety. (Id.). Plaintiff saw Dr. Bonner for treatment of her forehead pain on November 13, 2002. (Tr. 144-46). Dr. Bonner found that plaintiff suffers from "significant anxiety, perhaps depression." (Tr. 146). Dr. Bonner noted that plaintiff experienced difficulty concentrating, and even had problems concentrating while he gave plaintiff directions during her examination. (Tr. 145). Dr. Bonner recommended psychiatric treatment. (Tr. 146).

On December 9, 2002, Paul Lohkamp, LCSW, found that plaintiff was depressed, with "severe somatization/pain syndrome." (Tr. 154). He recommended psychotherapy in conjunction with medical management from Dr. Lafferty. (Id.). Mr. Lohkamp saw plaintiff on nine subsequent occasions, from December 2002 to June 2003. (Tr. 156-64). On December 10, 2002, Dr. Lafferty diagnosed plaintiff with Major Depressive Disorder, recurrent, moderate with anxiety; and Generalized Anxiety Disorder, and prescribed the antidepressant Lexapro. (Tr. 152). On April 21, 2003, Dr. Moeser diagnosed plaintiff with "severe fibromyalgia with underlying anxiety and depression," along with "some degenerative joint disease," and spondylosis. (Tr.

166).

The ALJ failed to discuss the substantial medical evidence pertaining to plaintiff's mental impairments that was dated after the expiration of plaintiff's insured status. The only evidence of plaintiff's mental impairments that the ALJ acknowledged was Dr. Logan's May 15, 2001 comment that plaintiff's symptoms could be connected to an underlying anxiety disorder. The ALJ discussed plaintiff's physical complaints that occurred after the expiration of her insured status, including abdominal pain that she experienced in October 2000, and back pain that she complained of in December 2001. The ALJ, however, did not mention any treatment that plaintiff sought for her mental impairments after the expiration of her insured status. Although an applicant must establish that she was disabled before the expiration of her insured status, evidence concerning ailments outside of the relevant time period can support or elucidate the severity of a condition. See Pyland v. Apfel, 149 F.3d 873, 878 (8th Cir. 1998). However, "evidence outside the relevant time period cannot serve as the only support for the disability claim." Id.

Here, although plaintiff was not formally diagnosed with major depressive disorder, generalized anxiety disorder, or fibromyalgia until after the expiration of her insured status, there is sufficient evidence of these impairments in the record during the relevant time period. As previously discussed, plaintiff complained of her head and upper body pain to a chiropractor (Tr. 258), to Dr. Jafri (Tr. 251-55), and to Christian Hospital (Tr. 239-47), all prior to the expiration of her insured status. Dr. Jafri prescribed Prozac on February 21, 2000. (Tr. 252). Plaintiff told Dr. Logan that her headaches began three to four years prior to her May 2001 visit and gradually became debilitating. (Tr. 236).

Plaintiff's testimony is also consistent with the presence of her impairments during the

relevant time period. Plaintiff testified that she experiences pain or pressure in her head constantly, which prevents her from thinking or functioning and causes a lack of energy. (Tr. 28). Plaintiff stated that she has been experiencing these symptoms since 1996. (Tr. 28). The testimony of plaintiff's daughter, Jamie Hartman, was supportive of plaintiff's testimony regarding her impairments. Ms. Hartman testified that plaintiff suffers from problems with sleeping, memory, concentration, and the ability to retain information, which Ms. Hartman attributed to plaintiff's fibromyalgia. (Tr. 37-38). Ms. Hartman stated that plaintiff has experienced problems with her memory and concentration for five to ten years. (Tr. 38). Ms. Hartman testified that plaintiff's symptoms gradually worsened and that they have been at the then-current level of severity for three to five years. (Tr. 39). Ms. Hartman stated that she visits plaintiff four to five times a week and has been assisting her by accompanying her to doctor appointments, helping with her fiances, and helping with cleaning for one to two years prior to the hearing. (Tr. 40-41). Ms. Hartman explained that she would have helped plaintiff sooner but plaintiff did not complain. (Tr. 41).

In sum, the objective medical evidence of record is supportive of the presence of depression, anxiety, and fibromyalgia prior to October 31, 2000. In addition, plaintiff's testimony, along with that of her daughter, is consistent with the presence of these impairments during the relevant period. As such, the ALJ erred in failing to discuss the significant medical evidence of plaintiff's mental impairments. Accordingly, the undersigned recommends that the decision of the Commissioner denying plaintiff's benefits be reversed and this matter be remanded to the ALJ in order for the ALJ to address plaintiff's mental impairments and to determine how plaintiff's impairments affect her ability to perform work-related activities. If the ALJ determines that

plaintiff is currently disabled, he should apply SSR 83-20 to determine whether plaintiff's onset date occurred prior to the expiration of her insured status.

RECOMMENDATION

IT IS HEREBY RECOMMENDED that, pursuant to sentence four of 42 U.S.C. § 605 (g), the decision of the Commissioner be **reversed** and this case be **remanded** to the Commissioner for further proceedings consistent with this Report and Recommendation and further that the court not retain jurisdiction of this matter.

The parties are advised that they have eleven (11) days in which to file written objections to this Report and Recommendation pursuant to 28 U.S.C. § 636(b)(1), unless an extension of time for good cause is obtained, and that failure to file timely objections may result in a waiver of the right to appeal questions of fact. See Thompson v. Nix, 897 F.2d 356, 357 (8th Cir. 1990).

Dated this 17th day of August, 2005.

Lewis M. Blanton

LEWIS M. BLANTON
UNITED STATES MAGISTRATE JUDGE